STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated standard survey was conducted 6/7/16 through 6/9/16. Four complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 120 certified bed facility was 69 at the time of the survey. The survey sample consisted of three current resident reviews (Residents 4 through 6) and three closed record reviews (Residents 1 through 3).

F 157 SS=G 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as

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Albemarle Complaint survey ending: 6/9/2016

The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

F157 Date 7/18/2016

How the corrective action will be accomplished for the resident(s) affected.

Patient #2 no longer resides at Albemarle Health and Rehabilitation Center.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/28/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, document review, clinical record review and complaint investigation, the facility staff failed to promptly notify the physician of a change in condition for one of 6 residents in the survey sample. When Resident #2 was assessed with altered mental status and increased confusion, facility staff failed to notify the physician that the resident had no urine output when catheterized for a urine sample. The physician was not informed the resident had refused meals and continued to receive oral antidiabetic medications. The resident was sent to the emergency room and diagnosed with severe hypoglycemia (low blood sugar) and acute renal failure. The resident was admitted to the hospital intensive care unit and later died due to acute renal failure and lactic acidosis that failed to respond to treatments.

Hypoglycemia is a condition of abnormally low blood sugar (glucose) and is commonly associated with the treatment of diabetes. The signs and symptoms of hypoglycemia should be recognized and treated promptly because untreated hypoglycemia may lead to seizures, loss of consciousness or death. "Immediate treatment of hypoglycemia involves quick steps to

How corrective action will be accomplished for those residents with the potential to be affected by the same practice.

Current 24 hour report will be reviewed since 6/9/2016 to identify patients with a change in condition and to ensure the physician was notified. Physician will be notified at that time of any identified change in condition lacking documentation of physician notification.

Measures in place to ensure practices will not occur.

Staff Development Coordinator/designee will in-service charge nurses on policy and procedure for Significant Change of Condition and Documentation Summary to include assessing and reporting to the physician signs and symptoms of change in condition.

How the facility plans to monitor and ensure correction is achieved and sustained.

Director of Nursing/designee will review 24 hour report five times a week for four weeks to identify patient change in condition and to ensure prompt notification of the physician.
Any deficient practice will result in re-education or disciplinary action as indicated.

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get your blood sugar level back into a normal range - about 70 to 110 milligrams per deciliter [mg/dL] ...either with high-sugar foods or medications. " (4)

The findings include:

Resident #2 was admitted to the facility on 4/12/16 and discharged to the emergency room on 5/5/16. Diagnoses for Resident #2 included status post hernia repair, heart failure, edema, type 2 diabetes, hypertension, pulmonary hypertension, hypoxemia, acute kidney injury, history of venous thrombosis, major depressive disorder, atherosclerotic heart disease, aortic valve stenosis and arthropathy. The minimum data set (MDS) dated 4/19/16 assessed Resident #2 with moderately impaired cognitive skills.

Resident #2's closed clinical record was reviewed on 6/8/16. The record documented a physician's order dated 4/12/16 for the antidiabetic medication Metformin 500 mg (milligrams) to be administered 3 times per day for the treatment of type 2 diabetes. The resident also had a physician's order dated 4/12/16 for the antidiabetic medicine Glimepiride 2 mg to be administered daily for the treatment of diabetes. The resident's medication administration records (MARs) documented these medications were administered as ordered from 4/12/16 through 9:00 a.m. on 5/5/16.

Nursing notes documented the following regarding a change in the resident's condition starting on 5/5/16.

5/5/16 at 12:52 a.m. -"Pt [patient] alert, confused. Insisting that she be able to put her feet on floor

Director of Nursing will report findings to the QA committee quarterly for tracking and trending.

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while being pushed in wheelchair...Appetite poor for dinner. Fluid intake fair...C/O [complained of] urinary frequency, refused to go into bathroom [bathroom]. Insisted on using bedpan, but produced no urine...Call to MD [physician]..."

5/5/16 at 4:32 a.m. - "resident is in bed noted with some altered mental status, she still verbalizes and is responding to questions appropriately especially when responding to family, v/s [vital signs] 97.9, 100, 20, 110/75 [temperature, pulse rate, respiration rate, blood pressure] and oxygen saturation 93% on room air. MD contacted and ordered UA [urinalysis], C&S [culture and sensitivity] catheterized x 1 without any result, at this time, no s/s [signs/symptoms] of pain noted..."

5/5/16 at 6:11 a.m. - Tramadol 50 mg administered for pain, "resident noted with agitation"

5/5/16 at 9:46 a.m. - "Resident displays altered mental status, increased edema of upper extremities, pain, and decreased verbal communication, abnormal movements of the upper extremities, and facial gestures of the mouth...Breath sounds, and vitals [vital signs] monitored. 120/80, 95%, 89, 95.4, 20 [blood pressure, oxygen saturation, pulse rate, temperature, respiration rate]...Transfer to [hospital] per family request."

The resident's food intake records documented the resident on most days since admission ate from 50% to 100 % of meals until the evening of 5/4/16. Intake records documented the resident refused dinner on 5/4/16 and refused breakfast on 5/5/16. The resident continued to receive the

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antidiabetic medications Metformin on 5/4/16 at 9:00 p.m., Glimepiride on 5/5/16 at 8:00 a.m. and the Metformin again on 5/5/16 at 9:00 a.m. There was no notification to the physician concerning the resident's lack of food intake.

A change in condition form dated 5/5/16 at 10:04 a.m. documented Resident #2 was assessed with altered mental status, edema and uncontrolled pain that started on the morning of 5/5/16. The form listed the resident's vital signs as: blood pressure of 120/80, pulse rate of 89, respiration rate of 20 and temperature of 95.4. The form also documented the resident's oxygen saturation rate at 95% on room air. The space for the most recent blood glucose level was blank. The assessment listed the resident had an abrupt change in cognition with increased confusion, edema and a decreased level of consciousness. The form listed the physician was notified of the resident's change in condition on 5/5/16 at 8:15 a.m. The form made no mention the resident had no urine when catheterized or had not eaten since lunch on 5/4/16.

There was no assessment of the resident's blood sugar level in response to the change in condition. Further review of Resident #2's clinical record documented no routine monitoring of the resident's blood sugar levels since her admission. A lab test performed on 4/26/16, signed by the physician on 5/3/16, documented the resident's blood sugar level was low with a reading of 64 mg/dL (milligrams/deciliter) with a normal range listed as 70 to 120. There were no physician orders to check or monitor the resident's blood sugar upon admission, in response to the lab work or at the time her condition changed on 5/5/16.

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The resident's care plan (revised 4/21/16) included no problems, goals and/or interventions regarding diabetes. The care plan made no mention the resident was diabetic and included no interventions regarding any possible side effects from her daily oral antidiabetic medications.

Hospital notes documented the resident arrived at the emergency room on 5/5/15 at 10:45 a.m. and was diagnosed with severe hypoglycemia. Emergency room notes dated 5/5/16 documented the resident was unresponsive upon arrival to the hospital. Notes documented, "...chief complaint of AMS [altered mental status]...Per EMS [emergency medical services]...they state that pt's [patient's] family checked on pt about 3 hours ago and found her with an altered mental status. They [EMS] note a blood sugar of 14 en route... and notes that she has received glucagon..." Diagnoses listed on the initial emergency room assessment included severe hypoglycemia, acute kidney injury, altered mental status, metabolic disarray most likely due to acute renal failure, lactic acidosis, urinary tract infection, suspected acute liver injury, coronary artery disease, type 2 diabetes and chronic systolic heart failure. The emergency record dated 5/5/16 listed the resident's blood glucose (sugar) level was undetectable upon arrival. The hospital history and physical dated 5/5/16 documented, "Fingerstick glucose 14 per EMS. Patient not eating well for a few days prior to admission. Most likely cause of hypoglycemia is decreased po [oral] intake combined with oral hypoglycemic medications (glimepiride, metformin)." The history and physical dated 5/5/16 defined metabolic disarray as abnormal lab results that

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included high sodium level of 125, high potassium level of 6.2, high phosphorus level of 6.6 "all in a setting of AKI [acute kidney injury] and lactic acidosis. Most likely etiology is acute renal failure..." (sic)

The resident was admitted to the hospital and died on 5/7/16 after she failed to respond to treatments. The hospital discharge summary dated 5/7/16 documented the resident had a history of coronary artery disease, chronic systolic heart failure, type 2 diabetes and hypertension and presented to the emergency room on 5/5/16 with altered mental status. The summary stated the resident was in the nursing facility following surgical repair for a hernia. The summary documented, "...A few days ago, she [Resident #2] began to have a decreased appetite. On the morning of admission, patient states that she remembers and [an] aide leaving her room, which normally happens around 7 am. Her daughter came to visit at 8:15 am and found her mother lying in bed moaning but otherwise unresponsive. EMS was called and she was taken into the ambulance. In the ambulance, she was found to have a glucose of 14. She was given glucagon and taken to the ED [emergency department], where repeated fingerstick was too low to measure...Initial labs in the ED were significant for AKI [acute kidney injury] and metabolic disarray as well as lactic acidosis..." The discharge summary dated 5/7/16 documented the resident was admitted to the medical intensive care unit for treatment and stated, "During her [Resident #2's] stay...her lactic acidosis failed to respond and she developed oliguric renal failure despite volume resuscitation...Despite interventions she failed to improve...dialysis was deferred and on 5/6 [2016] at which time

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[Resident #2] was transitioned to comfort care measures. Cause of death is acute oliguric renal failure and refractory lactic acidosis."

The nurse caring for Resident #2 during the early morning hours on 5/5/16 was on leave and not available for interview. On 6/8/16 at 9:10 a.m. the director of nursing (DON) was interviewed about Resident #2's change in condition on 5/5/16. The DON stated there were no physician orders to monitor or check Resident #2's blood sugar levels during her stay or on 5/5/16 other than the lab on 4/26/16. The DON stated blood sugar checks required a physician's order. The DON stated the physician was called but there was no indication the physician was made aware of the lack of urine output or lack of food intake.

On 6/8/16 at 9:40 a.m. the nurse practitioner (NP) that cared for Resident #2 was interviewed about the resident's blood sugar monitoring and change in condition. The NP stated Resident #2 had been on oral diabetic medicines "for a long time." The NP stated she could not speak for the physician about when blood sugar checks should have been ordered. When asked if the oral diabetic medicines (Metformin, Glimepiride) should have continued when the resident was not eating, the NP stated she probably would have held the diabetic medicines if she knew she was not eating. The NP stated she was not made aware the resident was refusing meals. The NP stated, "The nurses have to let us know."

On 6/8/16 at 2:45 p.m. the registered nurse consultant (RN #2) was interviewed about any assessment of the resident's blood sugar level or notification concerning the lack of urine output and meal refusals. RN #2 stated on the evening

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of 5/4/16 the resident started with poor appetite. RN #2 stated the physician was called and the nurses were pushing fluids. RN #2 stated the physician ordered a urinalysis and the nurse catheterized the resident but was unable to get any urine. RN #2 stated she found nothing in the record indicating the nurse called the physician concerning the lack of urine output. RN #2 presented a copy of the change of condition form dated 5/5/16. RN #2 stated the form listed the physician was called on 5/5/16 at 8:15 a.m. but there were no orders given to check the resident's blood sugar. Concerning notification about the lack of urine output and meal refusal, RN #2 stated, "If they [nurses] notified the physician they didn't document it."

On 6/8/16 at 3:15 p.m. Resident #2's physician was interviewed about the change of condition and lack of blood sugar monitoring. After reviewing the clinical record the physician stated, "I would have expected her [Resident #2's] sugars to have been checked." The physician stated the resident had severe congestive heart failure and "massive" edema and he felt most of her decline was related to her heart failure. The physician stated the resident's right sided heart failure caused liver congestion which made treatments to correct abnormal blood sugars difficult. When asked about the resident's altered mental status and documented change in condition on 5/5/16, the physician stated, "Acutely I would have expected them [nurses] to assess [blood sugar level]." The physician stated, "In retrospect we should have been monitoring her [Resident #2's] blood sugars." When asked about any knowledge that the resident was catheterized and had no urine output at 4:32 a.m. on 5/5/16, the physician stated he did not recall

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any notification about lack of urine output. Concerning notification about the lack of urine output, the physician stated, "I would have thought a change in condition would create a call." The physician was shown the hospital discharge summary and asked to define the diagnosis of "refractory hypoglycemia." The physician stated refractory hypoglycemia was low blood sugar that would not respond to treatments and this was most likely related to the resident's severe heart failure and subsequent organ failure. The physician stated the resident's outcome would not have changed even with earlier treatment of the low blood sugar due to her organ failure but stated again he would have expected a blood sugar assessment when the resident became acutely ill. When asked why the resident's blood sugar level was not routinely checked especially with her history of heart failure, the physician stated he had no explanation of why Resident #2's blood sugar levels were not monitored.

On 6/8/16 at 4:10 p.m. the DON was interviewed about the expected response from nurses when no urine was obtained when catheterized. The DON stated nurses should have called the physician about not getting any urine. On 6/9/16 at 9:10 a.m. the DON was asked about any standing orders regarding diabetic care. The DON stated the facility had no standing orders for diabetics. The DON stated all orders for diabetic management were ordered by the physician for each resident.

The Lippincott Manual of Nursing Practice 10th edition on page 952 describes diabetes mellitus as "a metabolic disorder characterized by hyperglycemia and results from defective insulin

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production, secretion, or utilization." Page 942 of this reference states type 2 diabetes is "formally known as non-insulin-dependent diabetes mellitus or adult-onset diabetes mellitus...caused by a combination of insulin resistance and relative insulin deficiency..." This reference stated on page 945, "Accurate determination of capillary blood glucose assists patients in the control and daily management of diabetes mellitus. Blood glucose monitoring helps evaluate effectiveness of medication...and assists in the evaluation of episodes of hypoglycemia and hyperglycemia to determine appropriate treatment." This reference on pages 962 and 963 includes in standards of care for diabetes, "Closely monitor blood glucose levels to detect hypoglycemia...Treat hypoglycemia promptly..." (1)

The Lippincott Manual of Nursing Practice 10th edition on page 795 defines acute kidney injury (AKI) as "a clinical syndrome in which there is a sudden decline in renal function. This results in disturbances in fluid and electrolyte balance, acid-base homeostasis, blood pressure regulation, erythropoiesis [red blood cell production], and mineral metabolism. It is frequently associated with an increase in BUN [blood, urea, nitrogen] and creatinine, oliguria (less than 500 mL [milliliters] urine/24 hours), hyperkalemia [elevated sodium level], and sodium and fluid retention." (1)

Lactic acidosis results from a buildup of lactic acid made by the body's cells when they do not have enough oxygen. Significant drops in blood pressure, heart failure, cardiac arrest and an overwhelming infection can cause lactic acidosis. (2)

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The Drug Information Handbook for Nursing 13th edition on pages 778 and 779 describes the medication Metformin as an antidiabetic agent used for the management of type 2 non-insulin dependent diabetes when hyperglycemia cannot be managed with diet and exercise. This reference lists a U.S. Boxed Warning for Metformin stating, "Lactic acidosis is a rare, but potentially severe consequence of therapy with metformin...Use caution in patients with congestive heart failure requiring pharmacologic management, particularly in patients with unstable or acute CHF [congestive heart failure]..." (3)

The Drug Information Handbook for Nursing 13th edition on pages 573 and 574 describes Glimepiride as a sulfonylurea antidiabetic agent used for the management of type 2 diabetes (non-insulin dependent) along with diet and exercise. This reference states glimepiride may be used in combination with metformin or insulin in patients whose hyperglycemia is not controlled with a single agent. This reference lists under warnings for glimepiride use, "All sulfonylurea drugs are capable of producing severe hypoglycemia. Hypoglycemia is more likely to occur when caloric intake is deficient...or when more than one glucose-lowering drug is used..." This reference states glimepiride should be given once daily with the first meal of the day and states, "Patients that are NPO [nothing by mouth] or require decreased caloric intake may need doses held to avoid hypoglycemia...Monitor glucose as recommended by prescriber..." (3)

These findings were reviewed with the administrator, director of nursing and corporate nursing consultants on 6/8/16 at 4:50 p.m. and on

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ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 12 6/9/15 at 11:00 a.m. This was a complaint deficiency. 1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. 2) What is Metabolic Acidosis? Lactic Acidosis. WebMD. 6/10/16. http://www.webmd.com (3) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011. (4) Hypoglycemia. Mayo Clinic. 1998 -2016. Mayo Foundation for Medical Education and Research. 6/14/16. <http://www.mayoclinic.org/diseases-conditions/hypoglycemia/basics/definition/con-20021103>			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 157	**F278 Date 7/18/2016** **How the corrective action will be accomplished for the resident(s) affected.** Patient #5's interview, including sections C for cognition, D for mood and J for pain was completed on 6/16/2016 to accurately assess patient's status. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Current patients' most recent MDS will be reviewed by regional consultant for accurate coding of assessment interviews for cognitive patterns (Section C), mood (Section D) and pain (Section J). An OBRA and/or PPS assessment will be scheduled for any patients identified with coding errors. **Measures in place to ensure practices will not occur.** Regional consultant will in-service MDS coordinator regarding MDS/RAI manual requirements for accurately assessing and coding cognitive patterns, mood and pain.	
		F 278		

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F 278	Continued From page 13 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete minimum data set (MDS) assessment for one of 6 residents in the survey sample. Resident #5's most recent MDS with an assessment reference date of 5/5/16 included no assessment of the resident's cognitive patterns, mood or pain. The findings include: Resident #5 was admitted to the facility on 2/19/16 with diagnoses that included end stage renal disease, dementia, diabetes, hypertension, atherosclerotic heart disease, heart failure, chronic pain, epilepsy, hypothyroidism, pressure ulcer and retinopathy. The MDS dated 2/26/16 assessed Resident #5 with short and long-term memory problems and severely impaired cognitive skills for decision-making. Resident #5's clinical record was reviewed on 6/8/16. The most recent MDS dated 5/5/16	F 278	**How the facility plans to monitor and ensure correction is achieved and sustained.** Regional consultant will review five MDS assessments weekly for four weeks to ensure presence of a complete minimum data set (MDS) assessment as indicated for cognitive patterns, mood and pain. Any deficient practice will result in re-education or disciplinary action as indicated. Administrator will report findings to the QA committee quarterly for tracking and trending.	

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included no assessment of the resident's cognitive patterns, mood or pain.

Section C of the 5/5/16 MDS for assessment of cognitive skill, memory and recall was not completed. There were no documented responses to the brief interview for mental status questions (sections C0200, C0300, C0400, C0500) or any staff assessment of the resident's mental status (sections C0700, C0800, C0900, C1000).

Section D of the 5/5/16 MDS for assessment of mood issues was not completed. There were no documented responses to the resident mood interview (section D0200) concerning interests, feelings of depression, feeling tired, poor appetite, feeling bad about self, trouble concentrating and restlessness. The section for staff assessment of the resident's mood (section D0500) was not completed and was marked only with dashes.

Section J of the 5/5/16 MDS for assessment regarding the resident's pain was not completed. There were no documented responses to the pain interview questions (sections J0300, J0400, J0500, J0600) regarding pain presence, pain frequency, pain effect on function and pain intensity. The section for staff assessment of indicators of pain (sections J0800, J0850) was incomplete and was marked only with dashes.

On 6/8/16 at 4:30 p.m. the director of nursing (DON) was interviewed about the missing assessment sections of Resident #5's MDS. On 6/9/16 at 9:10 a.m. the DON stated the sections with missing assessments were those that included interview questions. The DON stated if

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the resident was not able to respond to the interview questions then the sections for staff assessment should have been completed. The DON stated she did not know why the mental status, mood or pain assessments were not completed on the 5/5/16 MDS.

On page C-4 of the MDS/RAI manual, it reads, " If the interview is stopped, do the following:
1. Code -, dash in C0400A, C0400B, and C0400C.
2. Code 99 in the summary score in C0500.
3. Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?
4. Complete the Staff Assessment for Mental Status "

On Page D-14 of the MDS/RAI manual, it reads, "Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9© Resident Mood Interview. This ensures that information about their mood is not overlooked."

On page J-8 of the MDS/RAI manual, it reads, "Code 0, no: if the resident responds " no " to any pain in the 5-day look-back period. Code 0, no: even if the reason for no pain is that the resident received pain management interventions. If coded 0, the pain interview is complete. Skip to Shortness of Breath item (J1100).

Code 1, yes: if the resident responds " yes " to pain at any time during the look-back period. If coded 1, proceed to items J0400, J0500, J0600 AND J0700.

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F 278	Continued From page 16 Code 9, unable to answer: if the resident is unable to answer, does not respond, or gives a nonsensical response. If coded 9, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800). " These findings were reviewed with the administrator, DON and corporate nursing consultant during a meeting on 6/8/16 at 4:50 p.m.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	**F279** **Date 7/18/2016** **How the corrective action will be accomplished for the resident(s) affected.** Patient #2 and #3 no longer reside at Albemarle Health and Rehabilitation Center. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Current patients will be reviewed to ensure a comprehensive care plan has been developed to include diabetic management, skin impairment and care of a Foley urinary catheter. A comprehensive care plan will be developed as indicated by the review.	

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by:
Based on staff interview, clinical record review and complaint investigation, the facility staff failed to develop a comprehensive care plan for two of 6 residents in the survey sample.

1. Resident #2, diagnosed with type 2 diabetes and treated daily with oral antidiabetic medicines, had no care plan developed regarding diabetic management and had no care plan developed regarding care of lower leg edema with blistering.

2. Resident #3 had no care plan developed regarding care of a Foley urinary catheter.

The findings include:

1. Resident #2 had no care plan regarding diabetic management and care of lower leg edema with blistering.

Resident #2 was admitted to the facility on 4/12/16 and discharged to the emergency room on 5/5/16. Diagnoses for Resident #2 included status post hernia repair, heart failure, edema, type 2 diabetes, hypertension, pulmonary hypertension, hypoxemia, acute kidney injury, history of venous thrombosis, major depressive disorder, atherosclerotic heart disease, aortic valve stenosis and arthropathy. The minimum data set (MDS) dated 4/19/16 assessed Resident #2 with moderately impaired cognitive skills.

Resident #2's closed clinical record was reviewed on 6/8/16. The record documented the resident had a diagnosis of type 2 diabetes. A physician's order dated 4/12/16 was documented for the antidiabetic medication Metformin 500 mg (milligrams) to be administered 3 times per day

Staff Development Coordinator or/designee will in-service charge nurses on policy and procedure for Care Planning to include initiation and activation during admission that meets a patient's medical, nursing, mental and psychosocial needs as well as any services required and identified in the comprehensive assessment to meet a patient's medical, nursing, mental and psychosocial needs. In-servicing will include developing an initial care plan on admission for ADLs, pain, skin, fall risk, nutrition and any other pertinent care areas such as diabetic management and care of a foley urinary catheter.

How the facility plans to monitor and ensure correction is achieved and sustained.

Unit Manager/designee will review new admissions and new orders five times a week for four weeks to identify services that are being provided and/or that have been identified in the comprehensive assessment to meet a patient's medical, nursing, mental and psychosocial needs for development of comprehensive care plan.

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F 279	Continued From page 18 for the treatment of type 2 diabetes. The resident also had a physician's order for the antidiabetic medicine Glimepiride 2 mg to be administered daily for the treatment of type 2 diabetes. The resident's medication administration records (MARs) documented these medications were administered as ordered from 4/12/16 through 9:00 a.m. on 5/5/16. The record assessed the resident had orders for leg wraps and elevation to treat severe edema of her lower extremities in addition to fluid filled blisters on her legs/feet. The resident's care plan (revised 4/21/16) failed to include problems, goals and/or interventions regarding the resident's diabetes. The care plan made no mention the resident was diabetic and included no interventions regarding any possible side effects from her daily oral antidiabetic medications. The care plan listed no problems, goals and/or interventions regarding the resident's lower extremity edema or care concerns regarding her blistered skin. On 6/9/16 at 9:10 a.m. the director of nursing (DON) was interviewed about Resident #2's care plan. The DON stated care plans were developed for residents within 24 hours of their admission. The DON stated problem areas on the care plan were identified based upon diagnoses, nursing assessments and resident issues. The DON stated the resident should have had a care plan regarding diabetes. The DON stated the resident had physician orders for care of the lower leg edema but these items were not on the care plan. These findings were reviewed with the administrator, director of nursing and corporate nurse consultants on 6/9/16 at 11:00 a.m.	F 279	Any deficient practice will result in re-education or disciplinary action as indicated. Director of Nursing will report findings to the QA committee quarterly for tracking and trending.	

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2. For Resident # 3 the facility staff failed to develop a comprehensive Care Plan to include Foley Catheter care.

Resident # 3 was admitted to the facility on 3/10/16. Diagnoses for Resident # 3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar).

A clinical record review was conducted on 6/8/16 and 6/9/16. Resident # 3's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident # 3 requiring extensive assistance for Activities of Daily Living care (ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission.

According to the physician orders summary dated 3/1/16 through 6/30/16 presented by the facility staff, three orders were written on 3/10/16 regarding Foley Catheter Care for resident #3.

The first order documented, "Change Foley Catheter q [every] 30 days and PRN [as needed]" with an order date of 3/10/16 but with a status of "discontinued" with no start or end date.

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The second order documented, "Foley care q shift" also with an order date of 3/10/16 and with a status of "discontinued" with no start or end date.

The third order documented, "Foley Catheter (specify size and balloon)" again with an order date of 3/10/16 but with a status of "discontinued" with no start or end date.

A clinical nursing note dated 3/25/16 documented the Foley Catheter was removed.

On the Care Plan dated 3/10/16 through 3/30/16 for Resident #3, it was documented that, "Resident [#3] has indwelling Catheter for a diagnosis of urinary retention" but only listed two interventions, "Monitor for discomfort on urination and frequency" and "Monitor/document for pain/discomfort due to catheter." Nowhere on the Care Plan was Foley Catheter Care mentioned as part of the interventions to obtain the goal, "Resident will be/remain free from catheter-related trauma through review date (target date 3/28/16)".

According to the DON (Administration #2) in an interview on 6/8/16 at 9:30 a.m. it is a standard of nursing practice (understood) to perform Foley Care when a catheter is present and to care plan this.

The facility staff could not produce any additional information to confirm that Foley Catheter Care was included in the Care Plan.

The facility administration was informed of the findings during a briefing on 6/9/16 at approximately 11:00 am. The facility did not

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F 279	Continued From page 21 present any further information about the findings. Complaint deficiency.	F 279	**F281 Date 7/18/2016** **How the corrective action will be accomplished for the resident(s) affected.** Patient #2 and #3 no longer reside at Albemarle Health and Rehabilitation Center. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Current patients progress notes since 6/9/2016 will be reviewed to identify potential services that failed to meet and/or follow professional standards of nursing practice or departed from appropriate care such as: 1. Assessing the patient properly and in a timely fashion 2. Following physician orders 3. Communicating information about the patient 4. Adhering to facility policy and procedure 5. Documenting appropriate information in the medical record 6. Administering medications as ordered. Any identified areas of non-compliance will result in re-education of the involved charge nurse.	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, document review, clinical record review and complaint investigation, the facility staff failed to follow professional standards of nursing practice for two of 6 residents in the survey sample. Facility staff failed to assess blood sugar levels in response to an abrupt change in condition resulting in severe hypoglycemia (harm) for Resident #2. Facility staff failed to document the administration of a controlled medication dispensed from the emergency drug supply for Resident #3. 1. Resident #2, diagnosed and treated with daily oral medication for diabetes, had no assessment of her blood sugar level after experiencing increased confusion, altered mental status, lack of appetite, worsening edema and lack of urinary output. Resident #2 continued to be administered antidiabetic medications after she refused meals and the physician was not notified that no urine was obtained when catheterized for a urine sample. The resident was sent to the emergency room at family request and was assessed as unresponsive upon arrival to the emergency room with severe hypoglycemia (low blood sugar). The resident was admitted to the hospital intensive	F 281		

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care unit and later died due to acute renal failure and lactic acidosis that failed to respond to treatments.

Hypoglycemia is a condition of abnormally low blood sugar (glucose) and is commonly associated with the treatment of diabetes. The signs and symptoms of hypoglycemia should be recognized and treated promptly because untreated hypoglycemia may lead to seizures, loss of consciousness or death. "Immediate treatment of hypoglycemia involves quick steps to get your blood sugar level back into a normal range - about 70 to 110 milligrams per deciliter [mg/dL] ...either with high-sugar foods or medications." (4)

2. Facility staff failed to document appropriate information (to whom it was given, when it was given, why it was given) in the clinical medical record for the use of Oxycodone 5 MG (milligrams) for Resident #3.

The findings included:

1. Resident #2, diagnosed and treated with daily oral medication for diabetes, had no assessment of her blood sugar level after experiencing increased confusion, altered mental status, lack of appetite, worsening edema and lack of urinary output. Resident #2 continued to be administered antidiabetic medications after she refused meals and the physician was not notified that no urine was obtained when catheterized for a urine sample. The resident was sent to the emergency room at family request and was assessed as unresponsive upon arrival to the emergency room with severe hypoglycemia (low blood sugar). The

Measures in place to ensure practices will not occur.

Staff Development Coordinator/ designee will in-service charge nurses on providing services that meet professional standards of nursing practice and/or that does not depart from appropriate care such as:

1. Assessing the patient properly and in a timely fashion
2. Following physician orders
3. Communicating information about the patient
4. Adhering to facility policy and procedure
5. Documenting appropriate information in the medical record
6. Administering medications as ordered.

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F 281	Continued From page 23	F 281	**How the facility plans to monitor and ensure correction is achieved and sustained.**	

resident was admitted to the hospital intensive care unit and later died due to acute renal failure and lactic acidosis that failed to respond to treatments.

Resident #2, diagnosed and treated with daily oral medication for diabetes, had no assessment of her blood sugar level after experiencing increased confusion, altered mental status, lack of appetite, worsening edema and lack of urinary output. Resident #2 continued to be administered antidiabetic medications after she refused meals and the physician was not notified that no urine was obtained when catheterized for a urine sample. The resident was sent to the emergency room at family request and was assessed as unresponsive upon arrival to the emergency room with severe hypoglycemia (low blood sugar). The resident was admitted to the hospital intensive care unit and later died due to acute renal failure and lactic acidosis that failed to respond to treatments.

Facility staff failed to follow physician orders, assess, and provide interventions for pain management for Resident #3.

The findings include:

1. Resident #2, diagnosed and treated with daily oral medication for diabetes, had no assessment of her blood sugar level after experiencing increased confusion, altered mental status, lack of appetite, worsening edema and lack of urinary output. Resident #2 continued to be administered antidiabetic medications after she refused meals and the physician was not immediately notified that no urine was obtained when catheterized for a urine sample. The resident was sent to the

Director of Nursing/designee will review 24 hour report and new orders five times a week for four weeks to identify any departure from appropriate care relating to following professional standards of nursing practice.
Unit Manager/designee will review controlled medications removed from the stat box weekly for four weeks to ensure appropriate administration/documentation as evidenced by documentation that the medication was removed from the stat box and signed on patient's eMAR when administered.

Any deficient practice will result in re-education or disciplinary action as indicated.

Director of Nursing will report findings to the QA committee quarterly for tracking and trending.

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emergency room nine hours after the change of condition at family request and was assessed as unresponsive upon arrival to the emergency room with severe hypoglycemia (low blood sugar). The resident was admitted to the hospital intensive care unit and later died due to acute renal failure and lactic acidosis that failed to respond to treatments.

Resident #2 was admitted to the facility on 4/12/16 and discharged to the emergency room on 5/5/16. Diagnoses for Resident #2 included status post hernia repair, heart failure, edema, type 2 diabetes, hypertension, pulmonary hypertension, hypoxemia, acute kidney injury, history of venous thrombosis, major depressive disorder, atherosclerotic heart disease, aortic valve stenosis and arthropathy. The minimum data set (MDS) dated 4/19/16 assessed Resident #2 with moderately impaired cognitive skills.

Resident #2's closed clinical record was reviewed on 6/8/16. A physician's order dated 4/12/16 was documented for the antidiabetic medication Metformin 500 mg (milligrams) to be administered 3 times per day for the treatment of type 2 diabetes. The resident also had a physician's order for the antidiabetic medicine Glimepiride 2 mg to be administered daily for the treatment of diabetes. The resident's medication administration records (MARs) documented these medications were administered as ordered from 4/12/16 through 9:00 a.m. on 5/5/16.

Nursing notes documented the following regarding a change in the resident's condition starting on 5/5/16.

5/5/16 at 12:52 a.m. -"Pt [patient] alert, confused.

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Insisting that she be able to put her feet on floor while being pushed in wheelchair...Appetite poor for dinner. Fluid intake fair...C/O [complained of] urinary frequency, refused to go into bathroom [bathroom]. Insisted on using bedpan, but produced no urine...Call to MD [physician]..."

5/5/16 at 4:32 a.m. - "resident is in bed noted with some altered mental status, she still verbalizes and is responding to questions appropriately especially when responding to family, v/s [vital signs] 97.9, 100, 20, 110/75 [temperature, pulse rate, respiration rate, blood pressure] and oxygen saturation 93% on room air. MD contacted and ordered UA [urinalysis], C&S [culture and sensitivity] catheterized x 1 without any result, at this time, no s/s [signs/symptoms] of pain noted..."

5/5/16 at 6:11 a.m. - Tramadol 50 mg administered for pain, "resident noted with agitation"

5/5/16 at 9:46 a.m. - "Resident displays altered mental status, increased edema of upper extremities, pain, and decreased verbal communication, abnormal movements of the upper extremities, and facial gestures of the mouth...Breath sounds, and vitals [vital signs] monitored. 120/80, 95%, 89, 95.4, 20 [blood pressure, oxygen saturation, pulse rate, temperature, respiration rate]...Transfer to [hospital] per family request."

The resident's food intake records documented the resident on most days since admission ate from 50% to 100 % of meals until the evening of 5/4/16. Intake records documented the resident refused dinner on 5/4/16 and refused breakfast

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on 5/5/16. The resident continued to receive the antidiabetic medications Metformin on 5/4/16 at 9:00 p.m., Glimepiride on 5/5/16 at 8:00 a.m. and the Metformin again on 5/5/16 at 9:00 a.m. There was no notification to the physician concerning the resident's lack of food intake.

A change in condition form dated 5/5/16 at 10:04 a.m. documented Resident #2 was assessed with altered mental status, edema and uncontrolled pain that started on the morning of 5/5/16. The form listed the resident's vital signs as: blood pressure of 120/80, pulse rate of 89, respiration rate of 20 and temperature of 95.4. The form also documented the resident's oxygen saturation rate at 95% on room air. The space for the most recent blood glucose level was blank. The assessment listed the resident had an abrupt change in cognition with increased confusion, edema and a decreased level of consciousness. The form listed the physician was notified of the resident's change in condition on 5/5/16 at 8:15 a.m. The form made no mention the resident had no urine when catheterized or had not eaten since lunch on 5/4/16.

There was no assessment of the resident's blood sugar level in response to the change in condition. Further review of Resident #2's clinical record documented no routine monitoring of the resident's blood sugar levels since her admission. A lab test performed on 4/26/16, signed by the physician on 5/3/16, documented the resident's blood sugar level was low with a reading of 64 mg/dL (milligrams/deciliter) with a normal range listed as 70 to 120. There were no physician orders to check or monitor the resident's blood sugar upon admission, in response to the lab work or at the time her condition changed on

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5/5/16.

The resident's care plan (revised 4/21/16) included no problems, goals and/or interventions regarding diabetes. The care plan made no mention the resident was diabetic and included no interventions regarding any possible side effects from her daily oral antidiabetic medications.

Hospital notes documented the resident arrived at the emergency room on 5/5/15 at 10:45 a.m. and was diagnosed with severe hypoglycemia. Emergency room notes dated 5/5/16 documented the resident was unresponsive upon arrival to the hospital. Notes documented, "...chief complaint of AMS [altered mental status]...Per EMS [emergency medical services]...they state that pt's [patient's] family checked on pt about 3 hours ago and found her with an altered mental status. They [EMS] note a blood sugar of 14 en route... and notes that she has received glucagon..." Diagnoses listed on the initial emergency room assessment included severe hypoglycemia, acute kidney injury, altered mental status, metabolic disarray most likely due to acute renal failure, lactic acidosis, urinary tract infection, suspected acute liver injury, coronary artery disease, type 2 diabetes and chronic systolic heart failure. The emergency record dated 5/5/16 listed the resident's blood glucose (sugar) level was undetectable upon arrival. The hospital history and physical dated 5/5/16 documented, "Fingerstick glucose 14 per EMS. Patient not eating well for a few days prior to admission. Most likely cause of hypoglycemia is decreased po [oral] intake combined with oral hypoglycemic medications (Glimepiride, metformin)." The history and physical dated 5/5/16 defined

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metabolic disarray as abnormal lab results that included high sodium level of 125, high potassium level of 6.2, high phosphorus level of 6.6 " all in a setting of AKI [acute kidney injury] and lactic acidosis. Most likely etiology is acute renal failure..." (sic)

The resident was admitted to the hospital and died on 5/7/16 after she failed to respond to treatments. The hospital discharge summary dated 5/7/16 documented the resident had a history of coronary artery disease, chronic systolic heart failure, type 2 diabetes and hypertension and presented to the emergency room on 5/5/16 with altered mental status. The summary stated the resident was in the nursing facility following surgical repair for a hernia. The summary documented, "...A few days ago, she [Resident #2] began to have a decreased appetite. On the morning of admission, patient states that she remembers and [an] aide leaving her room, which normally happens around 7 am. Her daughter came to visit at 8:15 am and found her mother lying in bed moaning but otherwise unresponsive. EMS was called and she was taken into the ambulance. In the ambulance, she was found to have a glucose of 14. She was given glucagon and taken to the ED [emergency department], where repeated fingerstick was too low to measure...Initial labs in the ED were significant for AKI [acute kidney injury] and metabolic disarray as well as lactic acidosis..." The discharge summary dated 5/7/16 documented the resident was admitted to the medical intensive care unit for treatment and listed, "During her [Resident #2's] stay...her lactic acidosis failed to respond and she developed oliguric renal failure despite volume resuscitation...Despite interventions she failed to improve...dialysis was

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deferred and on 5/6 [2016] at which time [Resident #2] was transitioned to comfort care measures. Cause of death is acute oliguric renal failure and refractory lactic acidosis."

The nurse caring for Resident #2 during the early morning hours on 5/5/16 was on leave and not available for interview. On 6/8/16 at 9:10 a.m. the director of nursing (DON) was interviewed about Resident #2's change in condition on 5/5/16. The DON stated there were no physician orders to monitor or check Resident #2's blood sugar levels during her stay or on 5/5/16 other than the lab performed on 4/26/16. The DON stated blood sugar checks required a physician's order. The DON stated the physician was called but there was no indication the physician was made aware of the lack of urine output or lack of food intake.

On 6/8/16 at 9:40 a.m. the nurse practitioner (NP) that cared for Resident #2 was interviewed about the resident's blood sugar monitoring and change in condition. The NP stated Resident #2 had been on oral diabetic medicines "for a long time." The NP stated she could not speak for the physician about when blood sugar checks should have been ordered. When asked if the oral diabetic medicines (Metformin, Glimepiride) should have continued when the resident was not eating, the NP stated she probably would have held the diabetic medicines if she knew she was not eating. The NP stated she was not made aware the resident was refusing meals. The NP stated, "The nurses have to let us know."

On 6/8/16 at 2:45 p.m. the registered nurse consultant (RN #2) was interviewed about any assessment of the resident's blood sugar level or notification concerning the lack of urine output

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and meal refusals. RN #2 stated on the evening of 5/4/16 the resident started with poor appetite. RN #2 stated the physician was called and the nurses were pushing fluids. RN #2 stated the physician ordered a urinalysis and the nurse catheterized the resident but was unable to get any urine. RN #2 stated she found nothing in the record indicating the nurse called the physician concerning the lack of urine output. RN #2 presented a copy of the change of condition form dated 5/5/16. RN #2 stated the form listed the physician was called on 5/5/16 at 8:15 a.m. but there were no orders given to check the resident's blood sugar. Concerning notification about the lack of urine output and meal refusal, RN #2 stated, "If they [nurses] notified the physician they didn't document it."

On 6/8/16 at 3:15 p.m. Resident #2's physician was interviewed about the change of condition and lack of blood sugar monitoring. After reviewing the clinical record the physician stated, "I would have expected her [Resident #2's] sugars to have been checked." The physician stated the resident had severe congestive heart failure and "massive" edema and he felt most of her decline was related to her heart failure. The physician stated the resident's right sided heart failure caused liver congestion which made treatments to correct abnormal blood sugars difficult. When asked about the resident's altered mental status and documented change in condition on 5/5/16, the physician stated, "Acutely I would have expected them [nurses] to assess [blood sugar level]." The physician stated, "In retrospect we should have been monitoring her [Resident #2's] blood sugars." When asked about any knowledge that the resident was catheterized and had no urine output at 4:32 a.m.

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on 5/5/16, the physician stated he did not recall any notification about lack of urine output. Concerning notification about the lack of urine output, the physician stated, "I would have thought a change in condition would create a call." The physician was shown the hospital discharge summary and asked to define the diagnosis of "refractory hypoglycemia." The physician stated refractory hypoglycemia was low blood sugar that would not respond to treatments and this was most likely related to the resident's severe heart failure and subsequent organ failure. The physician stated the resident's outcome would not have changed even with earlier treatment of the low blood sugar due to her organ failure but stated again he would have expected a blood sugar assessment when the resident became acutely ill. When asked why the resident's blood sugar level was not routinely checked especially with her history of heart failure, the physician stated he had no explanation of why Resident #2's blood sugar levels were not monitored.

On 6/8/16 at 4:10 p.m. the DON was interviewed about the expected response from nurses when no urine was obtained when catheterized. The DON stated nurses should have called the physician about not getting any urine. On 6/9/16 at 9:10 a.m. the DON was asked about any standing orders regarding diabetic care. The DON stated the facility had no standing orders for diabetics. The DON stated all orders for diabetic management were ordered by the physician for each resident.

The Lippincott Manual of Nursing Practice 10th edition on page 952 describes diabetes mellitus as "a metabolic disorder characterized by

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hyperglycemia and results from defective insulin production, secretion, or utilization." Page 942 of this reference states type 2 diabetes is "formally known as non-insulin-dependent diabetes mellitus or adult-onset diabetes mellitus...caused by a combination of insulin resistance and relative insulin deficiency..." This reference stated on page 945, "Accurate determination of capillary blood glucose assists patients in the control and daily management of diabetes mellitus. Blood glucose monitoring helps evaluate effectiveness of medication...and assists in the evaluation of episodes of hypoglycemia and hyperglycemia to determine appropriate treatment." This reference on pages 962 and 963 includes in standards of care for diabetes, "Closely monitor blood glucose levels to detect hypoglycemia...Treat hypoglycemia promptly..." (1)

The Lippincott Manual of Nursing Practice 10th edition on page 795 defines acute kidney injury (AKI) as "a clinical syndrome in which there is a sudden decline in renal function. This results in disturbances in fluid and electrolyte balance, acid-base homeostasis, blood pressure regulation, erythropoiesis [red blood cell production], and mineral metabolism. It is frequently associated with an increase in BUN [blood, urea, nitrogen] and creatinine, oliguria (less than 500 mL [milliliters] urine/24 hours), hyperkalemia [elevated sodium level], and sodium and fluid retention." (1)

Lactic acidosis results from a buildup of lactic acid made by the body's cells when they do not have enough oxygen. Significant drops in blood pressure, heart failure, cardiac arrest and an overwhelming infection can cause lactic acidosis. (2)

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The Drug Information Handbook for Nursing 13th edition on pages 778 and 779 describes the medication Metformin as an antidiabetic agent used for the management of type 2 non-insulin dependent diabetes when hyperglycemia cannot be managed with diet and exercise. This reference lists a U.S. Boxed Warning for Metformin stating, "Lactic acidosis is a rare, but potentially severe consequence of therapy with metformin...Use caution in patients with congestive heart failure requiring pharmacologic management, particularly in patients with unstable or acute CHF [congestive heart failure]..." (3)

The Drug Information Handbook for Nursing 13th edition on pages 573 and 574 describes Glimepiride as a sulfonylurea antidiabetic agent used for the management of type 2 diabetes (non-insulin dependent) along with diet and exercise. This reference states glimepiride may be used in combination with metformin or insulin in patients whose hyperglycemia is not controlled with a single agent. This reference lists under warnings for glimepiride use, "All sulfonylurea drugs are capable of producing severe hypoglycemia. Hypoglycemia is more likely to occur when caloric intake is deficient...or when more than one glucose-lowering drug is used..." This reference states glimepiride should be given once daily with the first meal of the day and states, "Patients that are NPO [nothing by mouth] or require decreased caloric intake may need doses held to avoid hypoglycemia...Monitor glucose as recommended by prescriber..." (3)

These findings were reviewed with the administrator, director of nursing and corporate

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nursing consultants on 6/8/16 at 4:50 p.m. and on 6/9/15 at 11:00 a.m.

This was a complaint deficiency.

1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

2) What is Metabolic Acidosis? Lactic Acidosis. WebMD. 6/10/16. http://www.webmd.com

(3) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

(4) Hypoglycemia. Mayo Clinic. 1998 -2016. Mayo Foundation for Medical Education and Research. 6/14/16. <http://www.mayoclinic.org/diseases-conditions/hypoglycemia/basics/definition/con-20021103>

2. Facility staff failed to document appropriate information (to whom it was given, when it was given, why it was given) in the clinical medical record for the use of Oxycodone 5 MG (milligrams) for Resident #3.

Resident # 3 was admitted to the facility on 3/10/16. Diagnoses for Resident # 3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar).

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A clinical record review was conducted on 6/8/16 and 6/9/16. Resident # 3's Admission Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident # 3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission.

The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident # 3 was 3/10/16 at approximately 1:00 pm. According to the MAR (Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #3 was admitted to the facility.

No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes documented that Resident #3 received any pain medication on 3/10/16. On a clinical note dated 3/10/16 in regards to Gabapentin 300 MG for chronic pain and at 14:17 (2:17 p.m.) indicated "Resident just got here and med have not arrived from pharmacy yet". According to the MAR (Medication Administration Record), Gabapentin 300 MG for chronic pain was given on 3/10/16 at 1700 (5:00 p.m.) and 2100 (9:00 p.m.). The Physician's Order for Gabapentin 300 MG read, "Give 300

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	495420	A. BUILDING _____ B. WING _____	C 06/09/2016

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ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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MG by mouth four times a day related to other chronic pain" with order and start date 3/10/16.

In a phone interview with Resident #3 on 6/8/16 at 2:06 pm Resident #3 explained that he was in pain on the day he was admitted to the facility. He could not recall when or who he had asked for pain medication from. He referred to all staff as the nursing staff. According to Resident #3 the facility staff did not have the pain medication delivered from the pharmacy when he asked. When asked which pain medication he was referring to he stated, "Oxycodone". There was no time frame given by Resident #3. Nursing notes do not convey that Resident #3 asked for or received pain medication on 3/10/16, the day of admission to the facility.

During an interview on 6/8/16 at 12:20 p.m. the DON (Director of Nursing) provided the Stat box contains on the Manifest and stated, "Oxycodone 5 MG is in the stat box". In an interview with the Pharmacy Consultant (Others #4) on 6/9/16 at 8:45 am, "Resident [#3's] medications were reviewed on March 24, 2016 (Pharmacy Review is always on the second to last or the last week of the month)". Others #4 confirmed that Oxycodone was available on March 10, 2016 in the facility Stat Box. Additionally, Others #4 stated, "usually I look at the MAR and reconcile when and to whom the stat box medications are given...I don't see it on the MAR for March 10, 2016...I only see it on March 11, 2016."

The Pharmacist (Others #4) explained the process of obtaining the medication from the Stat Box. First the doctor must be notified of a request for medication then a hard copy script must be sent to facility and to the pharmacy. Once the

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F 281	Continued From page 37	F 281		

pharmacy receives the script the doctor is authorizing access to the Stat Box so the pharmacy sends an access code to the facility to open the Stat Box. This new prescription negates the previous order (usually for a 30 pill supply) and a new script must be written for the next day.

Three documents were presented by the Pharmacist (Others #4) on 6/9/16 at 9:30 am. First, the Request for Removal of controlled substance Medication from the Contingency Supply authorizing the facility staff to remove Oxycodone 5 MG from the stat box on 5/10/16 at 7:04 p.m. with a fax time of 7:33 p.m. and labeled "URGENT". Second, the faxed physicians order dated 3/10/16 at 8:07 p.m. for Resident #3 for Oxycodone 5 MG, 1 every 6 hours for pain with a note "MD (doctor) wants 1 out of stat box." Third, the document entitled, "Timeliness of Receiving New Admission Medications" documented the initial admission order was received by the pharmacy on 3/10/16 at 1:53 p.m. and the original order was filled and received by the nursing center on 3/10/16 at 10:52 p.m. with an additional note, "Oxy [Oxycodone] 5 MG #1 tablet on 3/10/16 at 7:04 p.m.; Medication procured from the control box."

Documentation supported that Oxycodone 5 MG was taken from the Stat Box on 3/10/16 at 7:04 p.m. however, no documentation nor interviews could support if Resident #3 actually received this medication. No one (nursing staff, pharmacist, or DON) could verify or account for where the medication (1 Oxycodone 5 MG tablet) taken from the stat box had gone.

According to the Pharmacist during an interview on 6/9/16 at 9:30 a.m., "We [Pharmacist and

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Nursing staff] have to reconcile to know where the medications are". According to the DON on 6/9/16 at 10:00 a.m. the nurse that pulled the medication from the stat box no longer works at the facility but "It is my expectation that we [nursing staff] need to account for each medication".

No documentation to support that pain medication was given to Resident #3 on 3/10/16 was presented nor was a pain assessment performed after admission on 3/10/16.

The DON noted, "There was a pain assessment upon admission" for Resident #3. The pain Assessment on 3/10/16 at 13:39 (1:39 p.m.) confirmed, "yes [pain present]; right knee, nerve pain" and a numerical rating score of 6 [out of 1 though 10, with 10 the most severe pain]. No other pain assessments were performed by the staff on 3/10/16 for Resident #3.

The Lippincott Manual of Nursing Practice 10th edition on page 16 states concerning nursing documentation, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." This reference on pages 16 and 17 states, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 39 patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered ..." (1) The facility administration was informed of the findings during a briefing on 6/9/16 at approximately 11:00 am. The facility did not present any further information about the findings. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. Complaint deficiency.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and complaint investigation, the facility staff failed to assess and implement interventions for pain management for one of 6 residents in the sample (Resident #3). Facility staff failed to follow physician orders, assess, and provide interventions for pain for Resident #3.	F 309	**F309** Date **7/18/2016** **How the corrective action will be accomplished for the resident(s) affected.** Patient #3 no longer resides at Albemarle Health and Rehabilitation Center.	

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F 309	Continued From page 40	F 309	**How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Current patients will be reviewed to ensure a pain assessment has been completed and interventions for pain management have been implemented. A pain assessment and interventions will be implemented for any patients identified without a pain assessment or without pain management interventions being in place.	

Facility staff failed to provide pain medication (Oxycodone 5 MG) as needed on 3/10/16 for Resident #3. No evidence was presented by facility staff that Resident #3 received Oxycodone 5 MG on 3/10/16, nor was there an assessment regarding Resident #3's pain, nor was there evidence of any other (non-pharmacological) interventions to assist Resident #3 with his pain on 3/10/16.

Resident # 3 was admitted to the facility on 3/10/16. Diagnoses for Resident # 3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar).

A clinical record review was conducted on 6/8/16 and 6/9/16. Resident # 3's Admission Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident # 3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission.

The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident # 3 was 3/10/16

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F 309	Continued From page 41	F 309	**Measures in place to ensure practices will not occur.**	

at approximately 1:00 pm. According to the MAR (Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #3 was admitted to the facility.

No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes document that Resident #3 received any pain medication on 3/10/16. On a clinical note dated 3/10/16 in regards to Gabapentin 300 MG for chronic pain and at 14:17 (2:17 p.m.) indicated "Resident just got here and med have not arrived from pharmacy yet". According to the MAR Gabapentin 300 MG for chronic pain was given on 3/10/16 at 1700 (5:00 p.m.) and 2100 (9:00 p.m.). The Physician's Order for Gabapentin 300 MG read, "Give 300 MG by mouth four times a day related to other chronic pain" with order and start date 3/10/16.

According to the Care Plan created on 3/11/16 and revised/canceled on 3/30/16, Resident #3 was at risk for pain. The goal read, "Resident will have decreased complaints of pain through next review" with three interventions: 1. "Encourage relaxation techniques and provide diversion activities", 2. "Medicate as ordered" and 3. "Position resident for comfort." There was no documentation that any of these Care Planned Interventions were used by staff on 3/10/16.

In a phone interview with Resident #3 on 6/8/16 at 2:06 pm Resident #3 explained that he was in pain on the day he was admitted to the facility on 3/10/16. He could not recall when or who he had asked for pain medication from. He referred to all staff as the nursing staff. According to Resident

Staff Coordinator/designee will in-service charge nurses on policy and procedure for Pain Management to include following physician orders, assessing, and providing interventions for pain management for acute and chronic pain on admission &/or new pain that is not usual for the patient, administration and effectiveness of pain medication, notification of physician when pain is not relieved, medication is not available, any unusual findings and specific interventions based on individual patient needs.
Staff Coordinator/designee will in-service charge nurses on process of obtaining controlled medications from the Stat Box and documenting administration afterwards in the clinical medical record to include appropriate information (to whom it was given, when it was given and why it was given).

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F 309	Continued From page 42	F 309		

#3 the facility staff did not have the pain medication delivered from the pharmacy when he asked. When asked which pain medication he was referring to he stated, "Oxycodone". There was no time frame given by the resident. Nursing notes do not convey that Resident #3 asked for or received pain medication on 3/10/16, the day of admission to the facility.

During an interview on 6/8/16 at 12:20 p.m. the DON (Director of Nursing) provided the Stat box contains on the Manifest and stated, "Oxycodone 5 MG is in the stat box". In an interview with the Pharmacy Consultant (Others#4) on 6/9/16 at 8:45 am, Resident #3's medications were reviewed on March 24, 2016 (Pharmacy Review is always on the second to last or the last week of the month). Others #4 confirmed that Oxycodone was available on March 10, 2016 in the facility Stat Box. Additionally, Others #4 stated, "Usually I look at the MAR and reconcile when and to whom the stat box medications are given...I don't see it on the MAR for March 10, 2016...I only see it on March 11, 2016."

The Pharmacist (Others #4) explained the process of obtaining the medication from the Stat Box. First the doctor must be notified of a request for medication then a hard copy script must be sent to facility and to the pharmacy. Once the pharmacy receives the script the doctor is authorizing access to the Stat Box so the pharmacy sends an access code to the facility to open the Stat Box. This new prescription negates the previous order (usually for a 30 pill supply) and a new script must be written for the next day.

Three documents were presented by the Pharmacist (Others #4) on 6/9/16 at 9:30 am.

How the facility plans to monitor and ensure correction is achieved and sustained.

Unit Manager/designee will review 24 hour report and documentation of new admissions five times a week for four weeks to ensure patients were assessed and interventions were implemented for pain management and that physician orders were followed. Unit Manager will review Stat Box manifest weekly for four weeks to ensure any removed controlled narcotic was documented afterwards in the clinical medical record to include appropriate disposition. Any deficient practice will result in re-education or disciplinary action as indicated.

Director of Nursing will report findings to the QA committee quarterly for tracking and trending.

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First, the Request for Removal of controlled substance Medication from the Contingency Supply authorizing the facility staff to remove Oxycodone 5 MG from the stat box on 5/10/16 at 7:04 p.m. with a fax time of 7:33 p.m. and labeled "URGENT". Second, the faxed physicians order dated 3/10/16 at 8:07 p.m. for Resident #3 for Oxycodone 5 MG, 1 every 6 hours for pain with a note "MD (doctor) wants 1 out of stat box." Third entities, "Timeliness of Receiving New Admission Medications" documented the initial admission order was received by the pharmacy on 3/10/16 at 1:53 p.m. and the original order was filled and received by the nursing center on 3/10/16 at 10:52 p.m. with an additional note, "Oxy [Oxycodone] 5 MG #1 tablet on 3/10/16 at 7:04 p.m.; Medication procured from the control box."

Documentation supported that Oxycodone 5 MG was taken from the Stat Box on 3/10/16 at 7:04 p.m. however, no documentation nor interviews could support if Resident #3 actually received this medication. No one (nursing staff, pharmacist, or DON) could verify or account for where the medication (1 Oxycodone 5 MG tablet) taken from the stat box had gone.

According to the Pharmacist during an interview on 6/9/16 at 9:30 a.m., we have to reconcile to know where the medications are. According to the DON on 6/9/16 at 10:00 a.m. the nurse that pulled the medication from the stat box no longer works at the facility but "It is my expectation that we need to account for each medication". No documentation was found to support that pain medication was given to Resident #3 on 3/10/16 nor was a pain assessment performed after admission on 3/10/16. The DON stated, "There was a pain assessment upon admission for

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F 309	Continued From page 44	F 309		

Resident #3". The admission pain assessment on 3/10/16 at 13:39 (1:39 p.m.) confirmed, "yes [pain present]; right knee, nerve pain" and a numerical rating score of 6 [out of 1 though 10, with 10 the most severe pain].

The Lippincott Manual of Nursing Practice 10th edition on page 16 states concerning nursing documentation, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." This reference on pages 16 and 17 states, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered ..." (1)

The facility administration was informed of the findings during a briefing on 6/9/16 at approximately 11:00 am. The facility did not present any further information about the findings.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

Complaint deficiency.

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F 315 SS=E	Continued From page 45 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315 F 315	**F315** Date **7/18/2016**	

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure that 1 of 6 residents (Resident #3) who was incontinent of bladder received appropriate services.

Resident #3 did not receive Foley Catheter Care from 3/10/16 through 3/25/16 as catheter care was not ordered, care planned, or documented in the clinical record (nursing notes and TAR-Treatment Administration Record).

The findings included:

Resident # 3 was admitted to the facility on 3/10/16. Diagnoses for Resident # 3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine),

How the corrective action will be accomplished for the resident(s) affected.

Patient #3 no longer resides at Albemarle Health and Rehabilitation Center.

How corrective action will be accomplished for those residents with the potential to be affected by the same practice.

Current patients will be reviewed to identify patients with a Foley Catheter and to ensure they are receiving catheter care as ordered, care planned and documented in the eTAR (electronic Treatment Administration Record).

Measures in place to ensure practices will not occur.

Staff Development Coordinator/designee will in-service charge nurses on providing appropriate services to patients with Foley Catheter to include an order for catheter care and to ensure the catheter is care planned and documented in the clinical record.

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aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar).

A clinical record review was conducted on 6/8/16 and 6/9/16. Resident # 3's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident # 3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission.

According to the physicians orders summary dated 3/1/16 though 6/30/16 presented by the facility staff, three orders were written on 3/10/16 regarding Foley Catheter Care for resident #3.

The first order documented, "Change Foley Catheter q [every] 30 days and PRN [as needed]" with an order date of 3/10/16 but with a status of "discontinued" with no start or end date.

The second order documented, "Foley care q shift" also with an order date of 3/10/16 and with a status of "discontinued" with no start or end date.

The third order documented, "Foley Catheter (specify size and balloon)" again with an order date of 3/10/16 but with a status of, "discontinued" with no start or end date.

According to the TAR (Treatment Administration Record) dated March 1 through March 30, 2016

How the facility plans to monitor and ensure correction is achieved and sustained.

Unit Manager/designee will review 24 hour report, new orders and documentation of new admissions five times a week for four weeks to ensure patients with a Foley Catheter have an order for catheter care, a care plan for the catheter and documentation in the clinical record that catheter care is being provided as ordered. Any deficient practice will result in re-education or disciplinary action as indicated.

Director of Nursing will report findings to the QA committee quarterly for tracking and trending.

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	495420	A. BUILOING _____ B. WING _____	C 06/09/2016

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ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

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only an "Unscheduled 'Other' Orders" documented, "Change Foley Cath [Catheter] q 30 days and PRN, Foley cath (specify size and balloon), Foley care q shift." On this TAR no staff had signed to indicate that Foley Cath Care was performed for Resident #3 from admission 3/10/16 until the Foley Catheter was removed according to a clinical nursing note on 3/25/16.

Foley catheter care was not mentioned in any clinical nursing or CNA (certified Nursing Assistant) notes. On the Care Plan Dated 3/10/16 through 3/30/16 for Resident #3, it was documented that, "resident [#3] has indwelling Catheter for a diagnosis of urinary retention" but only listed two interventions, "Monitor for discomfort on urination and frequency" and "Monitor/document for pain/discomfort due to catheter."

Nowhere on the Care Plan was Foley Catheter Care mentioned as part of the interventions to obtain the goal, "Resident will be/remain free from catheter-related trauma through review date (target date 3/28/16)".

According to the DON (Administration #2) in an interview on 6/8/16 at 9:30 a.m. it was stated, "We know cath [Catheter] care was done, we just sign off on the TAR [Treatment Administration Record]". She also stated that catheter care was discontinued on the physician's orders- "There should be orders" and that no one had signed off on the TAR that it was completed.

In an interview with CNA #1 (worked with Resident #3 on the 7 a.m. to 3 p.m.) on 6/8/16 at 12:03 p.m. she stated, "I performed Foley care each day with a shower or bed bath" and

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"resident requested daily showers" and "There is nowhere to document Foley care but showers are documented on the ADL [Activities of Daily Living] assignment sheets." On 6/8/16 at 12:05 p.m. the DON was asked to locate any other CNAs that worked with Resident #3 that could confirm that Foley Catheter Care was performed each shift. No other CNAs were able to verify that Foley Catheter Care was performed each shift.

According to Resident # 3 on 6/8/16 at 2:06 p.m. "Catheter care [catheter cleaned/sanitized] was never performed, staff would empty the bag when it was very full and checked it [the bag] but not sure how often [the bag was checked]."

According to the Corporate RN (Registered Nurse- Administration #3) on 6/9/16 at approximately 9:15 a.m., the facility policy entitled, "Ancillary Nursing Care and Services" provided the policy and procedure protocol for Foley Catheter Care. According to the facility policy with an effective date of 2/1/15, the facility staff may 1. Utilize Mosby's Textbook for Long-Term Care Assistants or an approved textbook as directed and 2. Specifics of care activities will be reflected in the patient's plan of care. The text heading "Caring for Persons with Indwelling Catheters" taken from Mosby's, 7th Edition, 2015, page 362 presented by Administrative staff #3 on 6/8/16 at 4:11 p.m. documented, "Provide catheter care according to the care plan-daily, twice a day, after bowel movements, ...some catheters consider perineal [cleaning the genitals and anus] care to be sufficient. Follow the care plan." The facility staff could not produce any additional information to confirm that Foley Catheter Care was performed for Resident #3 or that Foley Catheter Care was

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F 315	Continued From page 49 included in the Care Plan. The facility administration was informed of the findings during a briefing on 6/9/16 at approximately 11:00 am. The facility did not present any further information about the findings. Complaint deficiency.	F 315		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	**F431** Date **7/18/2016** **How the corrective action will be accomplished for the resident(s) affected.** Patient #3 no longer resides at Albemarle Health and Rehabilitation Center. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The facility stat box manifest will be reviewed for any controlled pain medication removed since 6/9/2016 to ensure reconciliation of the narcotic and to ensure appropriate documentation in the clinical medical record (to whom it was given, when it was given and why it was given). Pharmacy will be notified of any discrepancy.	

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abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to reconcile a narcotic (Oxycodone 5 Milligrams) taken from the state box for 1 of 6 residents (Resident #3).

The Pharmacist (Others #4) failed to reconcile a narcotic (Oxycodone 5 MG tablet) with the MAR (Medication Administration Record and Clinical Nursing Record) taken form the stat box on 3/10/16 at 7:04 p.m. to relieve Resident #3's pain.

The findings included:

Resident # 3 was admitted to the facility on 3/10/16. Diagnoses for Resident # 3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar).

A clinical record review was conducted on 6/8/16 and 6/9/16. Resident # 3's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental

Measures in place to ensure practices will not occur.

Staff Development Coordinator/designee will in-service charge nurses on process of reconciling a narcotic taken from the stat box and documenting administration afterwards in the clinical medical record to include appropriate information (to whom it was given, when it was given and why it was given).

How the facility plans to monitor and ensure correction is achieved and sustained.

Unit Manager will review Stat Box manifest weekly for four weeks to ensure any removed controlled narcotic was reconciled and documented afterwards in the clinical medical record to include appropriate disposition. Any deficient practice will result in re-education or disciplinary action as indicated.

Director of Nursing will report findings to the QA committee quarterly for tracking and trending.

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Status) of 15. In addition, the MDS coded Resident # 3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission.

The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident # 3 was 3/10/16 at approximately 1:00 pm. According to the MAR (Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #2 was admitted to the facility.

No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes documented that Resident #3 received any pain medication on 3/10/16.

In a phone interview with Resident #3 on 6/8/16 at 2:06 pm it was explained that he was in pain on the day he was admitted to the facility. He could not recall when or who he had asked for pain medication from. He referred to all staff as the nursing staff. According to Resident #3 the facility staff did not have the pain medication delivered from the pharmacy when he asked. When asked which pain medication he was referring to he stated, "Oxycodone". There was no time frame given by the resident. Nursing notes do not convey that Resident #3 asked for or received pain medication on 3/10/16, the day of admission to the facility.

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During an interview on 6/8/16 at 12:20 p.m. the DON (Director of Nursing) provided the Stat box contains on the Manifest and stated, "Oxycodone 5 MG is in the stat box". In an interview with the Pharmacy Consultant (Others#4) on 6/9/16 at 8:45 am, Resident #3's medications were reviewed on March 24, 2016 (Pharmacy Review is always on the second to last or the last week of the month). Others #4 confirmed that Oxycodone was available on March 10, 2016 in the facility Stat Box. Additionally, Others #4 stated, "usually I look at the MAR and reconcile when and to whom the stat box medications are given...I don't see it on the MAR for March 10, 2016...I only see it on March 11, 2016."

The Pharmacist (others #4) explained the process of obtaining the medication from the Stat Box. First the doctor must be notified of a request for medication then a hard copy script must be sent to facility and to the pharmacy. Once the pharmacy receives the script the doctor is authorizing access to the Stat Box so the pharmacy sends an access code to the facility to open the Stat Box. This new prescription negates the previous order (usually for a 30 pill supply) and a new script must be written for the next day.

Three documents were presented by the Pharmacist (Others #4) on 6/9/16 at 9:30 am. First, the Request for Removal of controlled substance Medication from the Contingency Supply authorizing the facility staff to remove Oxycodone 5 MG from the stat box on 5/10/16 at 7:04 p.m. with a fax time of 7:33 p.m. and labeled "URGENT". Second, the faxed physicians order dated 3/10/16 at 8:07 p.m. for Resident #3 for Oxycodone 5 MG, 1 every 6 hours for pain with a

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note "MD (doctor) wants 1 out of stat box." Third entitled, "Timeliness of Receiving New Admission Medications" documented the initial admission order was received by the pharmacy on 3/10/16 at 1:53 p.m. and the original order was filled and received by the nursing center on 3/10/16 at 10:52 p.m. with an additional note, "Oxy [Oxycodone] 5 MG #1 tablet on 3/10/16 at 7:04 p.m.; Medication procured from the control box."

Documentation supported that Oxycodone 5 MG was taken from the Stat Box on 3/10/16 at 7:04 p.m. however, no documentation nor interviews could support if Resident #3 actually received this medication. No one (nursing staff, pharmacists, or DON) could verify or account for where the medication (Oxycodone 5 MG) had gone.

According to the Pharmacist during an interview on 6/9/16 at 9:30 a.m., we have to reconcile to know where the medications are. According to the DON on 6/9/16 at 10:00 a.m. the nurse that pulled the medication from the stat box no longer works at the facility but "It is my expectation that we need to account for each medication" No documentation was found to support that pain medication was given to resident #3 on 3/10/16 nor was a pain assessment performed after admission on 3/10/16. The DON stated, "There was a pain assessment upon admission" for Resident #3. The pain assessment on 3/10/16 at 13:39 (1:39 p.m.) confirmed, "yes [pain present]; right knee, nerve pain" and a numerical rating score of 6 [out of 1 through 10, with 10 the most severe pain]. No other pain assessments were performed by the staff on 3/10/16 for Resident #3.

The Lippincott Manual of Nursing Practice 10th edition on page 16 states concerning nursing

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documentation, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." This reference on pages 16 and 17 states, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered ..." (1)

The Emergency Medication Supplies Policy last revised on 01/01/13 entitled, "Long-Term Care Facilities Receiving Pharmacy Products and Services from the Pharmacy" documented the expectation, ...Pharmacy to identify which Emergency Medication Supplies have been accessed" and "facility should notify Pharmacy of withdrawals..." and "Facility should return opened boxes to Pharmacy for review and reconciliation of any discrepancies."

The facility administration was informed of the findings during a briefing on 6/9/16 at approximately 11:00 am. The facility did not present any further information about the findings.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

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F 431	Continued From page 55 Complaint deficiency.	F 431		